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ABSTRACT

School-based clinics (SBCs) are comprehensive primary health care facilities located within or on the grounds of middle, junior, or senior high schools. Varying in size and organizational structure, SBCs have emerged as an effective model for advancing adolescent health. They have gained attention because of their potential for treating problems such as inadequate access to health care, unwanted pregnancy, premature parenting, early withdrawal from school, depression and stress, and substance abuse. While school-based health centers will not resolve all these complex problems, they are greatly needed because of economic factors limiting health care access and age-related factors related to adolescent growth and development, risk-taking behavior and violence, sexuality, and the psychological transition to adulthood. SBCs are proving successful because they are accessible and comprehensive, facilitate feedback and compliance, have community suport, deal with early and unprotected sexual activity, and involve parents. In fact, clinic staff work together with parents, school counselors, nurses, administrators, and community health care workers to solve teens' problems and help families function. This guide documents broad national support for the SBC concept, includes sample resolutions and policy statements, outlines background information on adolescents' health and the need for SBCs, and lists resources to provide a greater understanding of these clinics. (MLH)

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SCHOOL-BASED CLINICS: A GUIDE FOR ADVOCATES

Developing Policy Statements
Educating Decision Makers
Enlisting Local Support

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
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The Support Center/CPO

The Support Center for School-Based Clinics, a project of the Center for Population Options, is a natural outgrowth of CPO's work to enhance the opportunities for young people in key decision-making areas of their lives. CPO encourages teens to continue their education, plan their families, obtain needed health and social services, and attain productive employment. CPO's special emphasis is on the interconnections among family formation and other "life actions."

In this regard, the Center for Population Options

- advocates access to accurate information and services concerning reproductive health and family planning options;
- focuses on adolescents as a critical group to reach with such information;
- implements programs– most often with youth-serving partners– that assist young people to obtain health care, plan for jobs and families, and generally gain more direction over their lives;
- conducts policy and program research to find better ways and means to help adolescents make key decisions for their present and future.

The Support Center was launched in April 1985 to serve as a national resource for school-based clinics (SBCs), one promising approach to adolescent health care. The Support Center works to increase communication among clinic practitioners, provide policy analysis and evaluation strategies, assist program staff and provide technical and professional services to groups developing clinics.

The Support Center fulfills its facilitator role through a variety of strategies, including one-on-one consultations, mid-size training workshops, and presentations at major national and state-wide conferences. Annually the Support Center hosts its own conference for professionals interested in health care delivery for young people. And each year it publishes a review of the field (the SBC *Update*), a quarterly newsletter, and occasional program resources. Since its inception, the project has been instrumental in sharing information, identifying strategies for program expansion, monitoring the development of new SBC sites, facilitating the exchange of expertise among clinic practitioners, and assisting with program evaluation.

SBCs: A Guide for Advocates

School-based clinics (SBCs) have emerged as an effective model for enhancing adolescent health. Over the last five years SBCs have gained considerable attention because of their potential effect on such problems as inadequate access to primary health care, unwanted pregnancy and premature parenting, early withdrawal from school, depression and stress, and substance abuse. Comprehensive school-based health centers will not, of course, provide a solution for all of these problems, for they are complex, interrelated and rooted in basic social and economic inequities in our society. However, SBCs are one innovative approach that communities are implementing in an effort to deliver needed services.

Because local efforts to establish and maintain SBCs are often aided by the broad support given to this program model by national and regional organizations, the Support Center has prepared this guide for advocates at all levels. The guide documents broad national support for the concept among a variety of groups that have adopted organizational statements and reports endorsing SBCs. The guide also includes sample resolutions and policy statements, as well as background information on adolescent health and on the advantages of comprehensive school-based health services. Finally, the guide contains a list of resources that will provide a broader understanding of the need for adolescent health services and of the potential of the SBC model.

The guide can be used in a variety of ways. Local advocates can distribute it to individuals and groups within their communities who might consider developing SBCs. Practitioners and interested citizens can use the guide as a source of information for educating policymakers who might face issues of funding for SBCs or attempts to limit the operation of clinics or prohibit their creation. Organizations developing a position on school-based clinics can use the guide in preparing policy statements, resolutions, and reports.

We need innovative strategies to address the enormous health problems the young of our nation face. Local advocacy, public awareness efforts, and broad organizational support are all essential to the continued growth of one such approach, the comprehensive school-based health center.

The Health of Adolescents–A National Concern

There is a tendency to think of adolescents as healthy. While it is true that the incidence of certain infectious diseases has declined, teens are subject to the "new morbidity," the results of the risk-taking behaviors common in adolescence. Certain societal stresses have intensified teen risk-taking in recent years. National rates of accidents, violence, suicide, drug use, early and unprotected sexual activity, unwanted pregnancy, and sexually transmitted diseases among teens describe a population in need of health care.

Figures from the early 1980's show that nearly one-third of children age 6 -16 had not visited a doctor in the preceding year and 15% had no regular source of medical care. Adolescents between the ages of 11 and 20 visited physicians' offices less often than did any other group although they had a higher rate of acute conditions (e.g., infection, influenza, injuries and the like). There are several factors that contribute to teens' lack of access to health care.

Economic factors are among the most important and the most obvious. The cost of health care is high, and increasing numbers of Americans are unable to afford it. In 1986 approximately 12 million children had neither public nor private health insurance coverage. This figure seriously underestimates the number of children who do not have access to adequate health care. Many of those who are insured are covered only in the event of illness or hospitalization, leaving families responsible for routine physicals and well-child care, as well as a portion of other medical expenses. Further, the number of un- and under-insured is increasing: in the public sector because federal budget cuts are restricting medical and social services and in the private sector because employers are reducing fringe benefits.

In addition to the economic factors limiting access to adequate health care, there are age-related factors peculiar to adolescence, factors related to growth and development, risk-taking behavior and violence, sexuality, and the psychological transition to adulthood. National statistics are testimony to the seriousness of these problems among American adolescents.

Health care may not be accessible to teens for other reasons as well. Doctors' offices and clinics are often open primarily during school hours, with little provision made for after-school or weekend care. Transportation to the source of care is often a problem also, especially in rural areas and in cities without good public transportation. In recent years this problem has grown as more mothers work outside the home, and thus parents are less available to transport their children to doctors' appointments.

All of these difficulties are intensified when teens seek medical care independently of their parents. Scheduling, transportation, cost of care, the assurance of confidentiality and legal consent issues together may present insurmountable obstacles for adolescents, obstacles for poor and affluent teens alike.

The combination of economic, age-related and other factors limiting access to health care makes adolescents a particularly hard group to reach. Evidence of their unmet need for care is the shocking fact that teens are the only group that has experienced an increase in mortality rate in the last twenty years. Clearly there is a critical need for better access to health care for adolescents.

School-Based Health Programs

Schools have long recognized the important link between health and education. At the end of the last century most schools instituted health programs designed to prevent the spread of infection. As that threat diminished, school health services gradually evolved into health education, screening, and referral programs — the model that is still most common today.

However, more than 20 years ago, the city of Cambridge, Massachusetts, was the first in the nation to take the next step in the evolution of school health services by instituting school-based, comprehensive health care for all children in the city. The success of this and other early programs and increasing awareness of the unmet health care needs of children, especially teens, have contributed to tremendous growth in the number of comprehensive school-based health programs over the last two

decades. As of the summer of 1988, there were 120 clinics in operation in middle, junior and senior high schools and more than 100 were planned. The existing clinics were part of 67 programs in 30 states.

Advantages of School-Based Programs

School-based clinics are comprehensive, primary health care facilities located within or on the grounds of middle, junior or senior high schools. They vary in size and organizational structure. Typically, they are staffed by a multi-disciplinary group of professionals with special expertise or interest in adolescent health. SBCs operate with a mix of public and private funds. In general, they are administered by organizations such as hospitals, departments of public health, private and nonprofit organizations, community health centers, and occasionally, school systems. SBCs are proving successful in delivering health care to adolescents for several reasons.

SBCs are accessible.

School-based clinics bring services to children. They eliminate the obstacles of transportation and scheduling and the crucial economic barriers to care. High levels of use, reported in studies of individual clinics, indicate that comprehensive school-based programs are filling a real need. Teens who responded to a recent CPO survey said that they used clinic services because of location and staff that care.

SBCs are comprehensive.

Children may not seek medical care because they cannot determine where their problem fits into the system of specialized health care providers. At other times they may not seek care because they fear the stigma attached to a certain kind of service. In other cases children may not seek care because they do not identify their condition as requiring attention. In all of these cases the comprehensive school-based clinic is in a position to reach children who would not receive care in a traditional system.

Table 1 lists the percentage

of clinics offering each of a number of health and educational services. (These data are based on a 1987 survey by the Support Center/Center for Population Options.) Although individual clinics vary in the precise mix of services they provide, all offer a comprehensive range. The integration of social and medical services within SBCs acknowledges the complex causes of many of the problems that adolescents face.

SBCs improve compliance.

Compliance is a major concern of all health care providers and a special problem when patients are children and adolescents. School-based health services have the particular advantage of proximity to patients, facilitating follow-up and improving compliance. In addition, the combination of medical care and counseling with health education, both in the classroom and in the clinic, reinforces important health issues and allows an emphasis on prevention, early intervention, and health promotion. Beyond the immediate goal of improving students' health status, school-based health programs can help students achieve lifestyles that will lead to productive futures.

SBCs have community support.

School-based clinics develop in areas where the local community has identified unmet health care needs among its children. An advisory group composed of school officials, local health care providers, health department representatives, parents, representatives of youth-serving agencies, and others establishes policy for the program, assists in community outreach, and may raise funds. Because school-based health services evolve in response to local needs, each program reflects community standards. Thus programs vary from school to school within a single city; this flexibility and the continuing responsiveness of clinics to local needs are among the greatest assets of SBCs.

SBCs deal with the problem of early, unprotected sexual activity.

The United States has the highest rates of pregnancy, birth, and abortion to teens among the industrialized nations. Each year nearly one million U.S. teens get pregnant. Eight out of ten of these pregnancies are unintended. Nearly half result in the birth of a

baby, and almost 60 percent of these infants are born out-of-wedlock. The serious negative consequences of teen pregnancy and parenthood are well-documented.

In addition to the problems associated with teen pregnancy, the dangers of sexually transmitted diseases (STDs) are increasing. For these reasons, reproductive health care is an essential part of the school-based clinic program.

Programs recognize that true prevention requires reaching young people before they become sexually active and encouraging the delay of sexual activity through abstinence. For sexually active teens, programs emphasize students' responsibility in their sexual activity and link the idea of family planning with life planning decisions. SBCs may refer, counsel, prescribe and/or distribute contraceptives, depending on locally determined standards. On average less than 25% of the services provided at SBCs have to do with reproductive health.

There is no evidence that the presence of a clinic in a school, and thus access to family planning services, increases the level of sexual activity among students. In fact, a few studies have found that students in schools with clinics tend to delay first intercourse. In addition, those sexually active students who are clinic users are more likely to have used a contraceptive at last intercourse.

SBCs involve parents.

The SBC maintains patient confidentiality while encouraging adolescents to involve adults in their lives. Parents are kept informed of clinic activities and regularly involved in clinic planning and advisory groups. Clinics typically require written consent from parents in order for students to receive medical care.

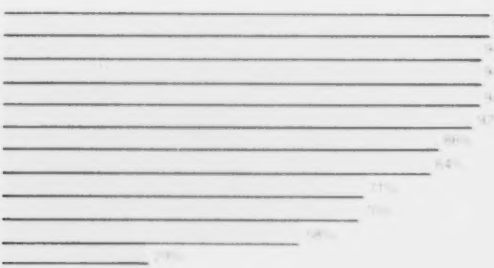
The clinic staff recognize that at times teens' assessments of their own situation are not enough. Often the involvement of adults other than the clinic staff is crucial. Clinic staff strive to work together with parents, school counselors, nurses, administrators, and community health care workers to solve teens' problems and help families function.

TABLE 1 (N=59 Clinics)

Percentage of Sites Providing a Range of Services

GENERAL HEALTH SERVICES

COUNSELING/EDUCATIONAL SERVICES



National Organizations with Policy Statements and/or Reports Favorable to School-Based Clinics

American Academy of Child and Adolescent Psychiatry

American Academy of Pediatrics

American Association of University Women

American College of Obstetricians and Gynecologists

American Jewish Congress

American Medical Association

American Public Health Association

American School Health Association

Central Conference of American Rabbis

Child Welfare League of America, Inc.

Commission on the Future of the South

National Academy of Sciences (National Research Council)

National Association of School Nurses, Inc.

National Conference of State Legislatures

National Education Association

National Governors' Association

National Organization for Women

National Parent and Teacher Association

Society for Adolescent Medicine

United Church Board for Homeland Ministries

State & Local Organizations with Policy Statements Favorable to School-Based Clinics

Chicago Area Parent and Teacher Association

D. C. Congress of Parents and Teachers

Illinois Public Health Association

New York State Parent and Teacher Association

Washington D.C. Urban League

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Report of the Council on Scientific Affairs

Recommendations

Ideally, every child should have a "medical home" where continuing and comprehensive health care is provided by a personal physician. When this is not possible, however, alternative methods for providing medical services need to be explored.

Given the fact that the American Medical Association has made a commitment to identifying and implementing sound strategies to protect and enhance the physical and mental well-being of adolescents and in recognition of limited but persuasive evidence that school-based health programs represent one strategy for addressing the problems associated with medically underserved youths, the following recommendations are offered:

1. That further objective research into the potential benefits and problems associated with school-based health services be undertaken by credible organizations in the public and private sectors.

2. That where school-based services exist, they meet the following minimum standards:

   a. Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis.

   b. On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would

include coordinating the health care of students with the student, the parents, the school, and the student's personal physician and assisting with the development and presentation of health education programs in the classroom.

c. There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders, and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment.

d. Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council.

e. Policies for ongoing monitoring, quality assurance, and evaluation should be established and executed.

f. Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted.

g. School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs.

h. Services provided should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

3. That the Council on Scientific Affairs continue to monitor developments in this area and report back to the Board of Trustees and the House of Delegates as appropriate.

GOVERNMENT RELATIONS
Kenneth F. Melley, Director

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MARY HATWOOD FUTRELL, President
KEITH GEIGER, Vice President
ROXANNE E. BRADSHAW, Secretary-Treasurer
DON CAMERON, Executive Director

C-9 Student Health and Personnel Services

The National Education Association believes that every student should have direct and confidential access to health, social, and psychological services within both school and community settings.

The Association also believes that health, social, and psychological services to children must be provided by appropriately licensed and [/or] certificated professional personnel in both settings.

The Association further believes that these services dealing with children's physical, mental, and psychological well-being are best delivered when there is coordination within the school, as well as among the school, home, and community.

These services must include—

a. Preventative programs to promote optimum wellness in physical, social, and emotional health to allow for the maximum level of school performance

b. Programs for early identification and diagnosis of health and/or learning disabilities

c. Programs—such as direct services within the schools and referrals to and coordination with community and local governmental agencies—that work to resolve identified disabilities

d. Programs that promote health awareness for students, school employees, parents, and community

e. Programs taught by specialists that include health education and physical education commensurate with maturation levels of children

f. Comprehensive school-based, community-funded student health care clinics that provide basic health care services (which may include diagnosis and treatment) to supplement, but not supplant, school nurses.

The Association urges that, if deemed appropriate by local choice, these health care services include family-planning counseling and access

to birth control methods and instruction in their use, and that school nurses be integrally involved in the design, development, and implementation of the clinic, serving as the nursing professional in the school-based clinic model.

The Association further believes that schools must assume an advocacy role for those students affected by circumstances that prevent them from functioning adequately in education settings.

The Association urges its affiliates to monitor relevant legislative issues. (69,88)

8705: Expansion and Funding of Comprehensive School-Based Clinics

The American Public Health Association

Recognizing that school-age populations have high rates of health problems and health-related risk-taking behaviors; and

Recognizing that one million adolescents become pregnant each year;[1] and

Further noting that too-early childbearing often results in a host of significant physical, developmental, and financial problems for both teenage parents and their children, including an increased incidence of low birthweight infants;[1,2] and

Recognizing that young people, particularly those in low-income communities, often do not have access to health services; and

Recognizing that there has been a long history of delivering health services to young people within the school context; and

Recognizing that school-based clinics are an innovative additional means for delivering nursing and medical social services to youth;[3] and

Understanding that school-based clinics provide comprehensive health services, which commonly include such services as athletic physicals, general health assessments, laboratory and diagnostic screening, immunizations, and first aid, and seek to meet urgent adolescent health needs in such areas as tobacco, alcohol and other drug use, adolescent pregnancy, mental health, and general primary health care; and where

implemented, such clinics have been heavily utilized;[4,5] therefore

1. Endorses comprehensive health services to school-based clinics, or other school-linked programs which coordinate with existing services;

2. Encourages local, state, and federal governments, school boards, health services, foundations, and other relevant entities to expand funding of comprehensive school-based clinics and coordinated services;

3. Recommends that school administrators, teachers, health and mental health personnel, students, parent-teacher associations and other community groups be included in the planning and implementation of such clinics;

4. Opposes restrictions of funding designed to prohibit family planning and sex education in comprehensive school-based clinics;

5. Endorses related innovative health promotion and disease and disability prevention programs; and

6. Urges comprehensive school-based clinics to include well-planned evaluations and standardized data collection as part of their clinic plan.

References:

1. Alan Guttmacher Institute: Teenage pregnancy: The problem that hasn't gone away. New York: AGI, 1981.

2. Senderowitz J, Paxman JM: Adolescent fertility: Worldwide concerns. Washington, DC: Population Reference Bureau, 1985.

3. Dryfoos J: School-based clinics: A new approach to prevention of adolescent pregnancy. Fam Plann Perspect March/April 1985.

4. Hadley BM, Lovick S, Kirby D: School-based health clinics: A guide to implementing programs. Washington, DC: Center for Population Options, 1986.

5. Center for Population Options: The facts: School-based clinics. Washington, DC: CPO, 1987.

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Minutes, Board of Directors
Appendix J
April 25-27, 1987

POLICY ON SCHOOL-BASED HEALTH CLINICS

Background

School-based health clinics are primary health care centers, located on the grounds of middle, junior and senior high schools and provide a variety of health and social services to young people throughout the school day. Although varying in size and organizational structure, these programs share a common goal: to ensure that students are physically and emotionally prepared to take full advantage of their daily educational opportunities.

School-based health clinics have developed out of a recognition by many health providers that adolescents, especially in low-income communities, exhibit unique health care needs. Adolescents differ from both young children and adults and therefore need to receive specialized care often not available through traditional pediatricians or internists. Health-care professionals have also

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realized the importance of incorporating education and counseling into adolescent health care.

Each local school-based clinic is designed exclusively to meet the needs of teens in its community. Yet nationwide, school-based clinics share these common characteristics:

1) A comprehensive set of services that commonly include athletic physicals, general health assessments, laboratory and diagnostic screening (e.g., sickle cell anemia and sexually transmitted disease screening), immunizations, first-aid and hygiene, family planning counseling and services, pre-natal and post-partum care, drug and alcohol abuse programs, nutrition and weight-loss programs and referrals for special medical care. Many school-based clinics address non-medical issues such as school absenteeism, the drop-out problem, day-care and family-counseling services. They differ from more traditional school health programs by having the authority to prescribe and/or dispense medications.

2) A holistic, multi-disciplinary team approach to the provision of services by a staff that possesses a wide range of abilities.

3) Extensive networking with existing community resources to mobilize and maximize available services for teens.

4) Location within or adjacent to a school building so that a significant level of cooperation and coordination of clinic services with the educational programs is accomplished.

5) Adolescent sexuality and reproductive health care as one of the major goals of the program, including the provision of family planning. School-based clinics recognize that if family planning is not incorporated into general health care, young

people will fail to learn that they are responsible for all aspects of their health.

6) Written parental consent before a student can receive medical services from the clinic. The parental consent form provides a clear description of all clinic services and additional important information for parents. Programs encourage parental participation in advisory groups and in individual consultations regarding their children's health. Some programs sponsor workshops which focus on parental effectiveness training and ways of improving parent-child communication.

7) Organized and managed by traditional health institutions, a majority of these programs are extensions of hospitals and public health departments. They are not run by the school system.

School-based health clinics have usually been the outgrowth of grass roots community commitment to improving the health status of teens. Generally an individual or agency recognizes that adolescents have many unmet health needs. Advisory-planning groups are formed, and a strategy for addressing those needs is determined which includes the establishment of a school-based clinic. Only with school board approval is a school-based clinic started. These programs have been organized with strong community involvement and support at their base, and they have been inspired and managed by the communities they serve.

Although there may be other health facilities in the community, it has been recognized that teens often do not use them. Because the services are typically fragmented and categorical, teens do not know where to go for specific types of services. Many teens delay seeking care for such sensitive problems as depression, drug abuse, alcohol abuse and family planning. By bringing health care to teens in the school setting, early detection and treatment can occur and positive preventive health behaviors can be promoted, and follow-up services provided. Furthermore, the adolescent is treated as a whole person with his or her

interconnected problems addressed together. The school-based clinic co-exists with other programs to maximize the services available to teens and serve the large numbers of teens who have no family doctor.

The staff of school-based clinics are chosen not only for their medical competency but for their ability to relate to teens. They recognize that teens often test a relationship by presenting minor symptoms (such as a sore throat) in an initial appointment and present a major concern (such as depression or venereal disease) only when trust has been established.

School-based clinics began operating in the early 1980's in several diverse communities: St. Paul, Minnesota, Kansas City, Missouri, and Alamosa County, Colorado. By 1985 forty school-based clinics were operating in seventeen states. These clinics began at the community level. By 1985 states were passing policies and laws that establish and define the school-based clinics. Now, alongside clinics that emerge solely because of community interest will be clinics that are sparked by special state and regional initiatives.

School-based clinics have demonstrated their success in a number of ways.

The rapid growth in the number of programs illustrates this innovative health care delivery model has gained the acceptance of many diverse communities. The Dusable Clinic in Chicago recorded more than 2,000 medical encounters in its first two months of operation. In Kansas City, 70% of the total student body uses the clinic for some type of service each year, in St. Paul about 75%, and in West Dallas about 85%. Clinics in St. Paul have demonstrated that they are effective in reducing unintended births and their side effects. The 12-month and 24-month contraceptive continuation rates were 93% and 82% (based on 1982 data). The birth rates dropped about half in the first school and by 40% in the four schools which have since opened clinics. About 80% of the teen mothers remained in school and only

1.4% of the teen mothers who remained in school had a repeat pregnancy within two years or until graduation.

School-based clinics have demonstrated that both the physical and emotional health of young people can be enhanced in the school setting. In practice, however, overcoming the barriers to the establishment of clinics has been difficult.

Catholic and religiously fundamentalist groups have expressed strong opposition to a school facility dealing with family planning. In reaction to such opposition, some school clinics have established policies to refer family planning; other clinics offer family planning counseling and prescriptions but do not fill prescriptions. Some communities, such as Baltimore, have established clinics across the street from schools. However, communities such as St. Paul, where Catholic opposition has been strong, are able to sustain a school-based clinic. The success record of those clinics has dissipated much of the opposition. Another barrier has been funding of clinics. Clinic administrators and directors have been continually challenged to find sources of income, especially in the decade when most social services have been frozen or cut back. Most clinics have combined funding from federal, state and local public and private monies. Block grants, Title X, Title XX and Medicaid have been the major sources of public money.

A United Church Board for Homeland Ministries policy that supports school-based clinics would strengthen the stand of United Church of Christ people and churches who are working toward the establishment of school-based clinics in their communities. Such a policy would provide a base from which the United Church Board for Homeland Ministries could encourage and organize community initiatives on school-based clinics and support local, state, and national legislation that supports school-based clinics.

Resolution

Whereas school-based clinics offer an integrated program of prevention, diagnosis, and treatment of adolescents, many of whom have no family physician;

Whereas current health facilities are scattered, inconvenient, often fragmented in service, and often unknown to adolescents;

Whereas school-based clinics offer accessible services to adolescents in one convenient place;

Whereas school-based clinics hire staff who are able to relate to adolescents and to their particular problems;

Whereas school-based clinics develop community support and require parental permission for treatment; and

Whereas, the school-based clinics presently in operation have served hundreds of previously unserviced adolescents and have diagnosed previously untreated and potentially dangerous health problems;

Therefore, be it resolved that the United Church Board for Homeland Ministries encourage the support of school-based clinics that are responsive to a wide range of adolescent health care needs;

Be it further resolved that the United Church Board for Homeland Ministries make interpretive material available to the churches and encourage United Church of Christ people, churches and mission groups to work toward the development of school-based clinics in locations where they are needed;

Be it further resolved that the United Church Board for Homeland Ministries provide interpretive materials in support of local, state and national legislation encouraging development of school-based clinics.

SAMPLE POLICY RESOLUTION ON SCHOOL-BASED CLINICS

WHEREAS, the Association believes that it must assume an advocacy role for students affected by health circumstances that prevent them from functioning adequately in educational settings; and

WHEREAS, during the course of a year thirty-one percent of young people aged six to sixteen do not visit a doctor; and

WHEREAS, fifteen percent of young people aged sixteen to seventeen have no regular source of medical care; and

WHEREAS, young people aged eleven to twenty have a lower rate of visits to physicians' offices than do any other age group, even though they have a higher incidence of acute conditions (sore throat, otitis media, etc.); and

WHEREAS, 2.5 million young people aged thirteen to nineteen are infected with sexually transmitted diseases each year; and

WHEREAS, 4,500 cases of detectable diseases causing death and mental retardation occur each year to youths aged six to sixteen; and

WHEREAS, 1 in 10 females aged thirteen to nineteen get pregnant each year; and

WHEREAS, the 124 school-based clinics (SBCs) in thirty states presently in operation have served hundreds of previously underserved adolescents and have diagnosed previously untreated and potentially dangerous health problems; and

WHEREAS, SBCs are an emerging and innovative means for delivering comprehensive medical and social services to youth and integrate prevention, diagnosis, treatment, and counseling with dramatically positive results, including reported reductions in the teen pregnancy rate; and

WHEREAS, SBCs show promise in changing many health behaviors that put adolescents at risk for teen pregnancy, drug and alcohol abuse, suicide, and school dropout;

THEREFORE BE IT RESOLVED, THAT THE ASSOCIATION

- urge area health providers to work with parents and schools to design locally appropriate SBC programs which recognize the need to coordinate with existing services; and
- encourage government at the local, state, and federal level as well as the private sector to explore the improvement of adolescent health services through the funding of SBCs; and
- endorse comprehensive health services in SBCs, including family planning and contraception; and
- oppose restrictions of funding for SBCs based on a component part of these services, such as family planning; and
- recommend collection and coordination of information as well as continued research on SBCs.

Resources

Adolescent Health

Hughes, Dana, *et al. The Health of America's Children: Maternal and Child Health Data Book.* Washington DC: Children's Defense Fund, 1987.

Johnson, Kay and Rosenbaum, S. *Building Health Programs for Teenagers.* Washington DC: Children's Defense Fund, 1986.

Pittman, Karen and Gina Adams. *Teenage Pregnancy: An Advocate's Guide to the Numbers.* Washington DC: Children's Defense Fund, Adolescent Pregnancy Prevention Clearinghouse, January/March 1988.

United States Bureau of the Census. *Statistical Abstract of the U.S.: 1987.* Washington DC: U. S. Government Printing Office, 1986.

School-Based Clinics

Dryfoos, Joy. School-Based Clinics: A New Approach to Preventing Adolescent Pregnancy? *Family Planning Perspectives,* 17 (2): 70-71, 1985.

Hadley, Elaine M., *et al. School-Based Health Clinics: A Guide to Implementing Programs.* Washington DC: Center for Population Options, 1986.

Keenan, Terrance. School-Based Adolescent Health Care Programs. *Pediatric Nursing,* 12(5):365-369, 1986.

Lovick, Sharon R. *The School-Based Clinic Update 1987.* Washington DC: The Center for Population Options, 1987.

Lovick, Sharon R. and Wanda F. Wesson. *School-Based Clinics: Update 1986.* Washington DC: The Center for Population Options, 1986.

Zabin, Laurie, *et al.* Evaluation of a Pregnancy Prevention Program for Urban Teenagers. *Family Planning Perspectives,* 18(3): 119-126, 1986.

TIPS FOR ADVOCATES: BUILDING A STRONG FOUNDATION

•KNOW THE OPPOSITION

Determine who they are: do their children attend the schools in question? Ask how or if they will be affected by the proposed program.

Attempt to involve the opposition and increase their knowledge by sponsoring tours of SBCs; allow opponents to speak to students and clinicians.

•RESPOND FROM A POSITION OF STRENGTH

Establish your credibility: collect and distribute local facts and trends; don't exaggerate or guess; get the facts right!

Anticipate the difficult questions and prepare responses ahead of time: be ready with facts and case studies.

Sincerely listen and learn about the real concerns of people.

•BROADEN YOUR SUPPORT BASE

Get involved in the community: join other groups, such as teen pregnancy or youth services coalitions.

Form a community advisory committee of parents, business leaders, clergy and lay leaders.

Get involved (on your own time) in a political campaign, registration drive or get-out-the-vote campaign.

•EXPAND YOUR VISIBILITY

Use public events: sponsor forums or participate in town meetings or health fairs.

Advertise community support: send copies of supportive letters or "thank you" letters from students to school board members and community leaders; encourage supportive constituency groups (PTA, youth leagues, health officials) to write legislators.

Educate the public: participate in radio talk shows, write letters to the editor of local papers, meet with editorial boards; repeat your message often and without apology.

$2.00

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